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## ACRONYMS AND GLOSSARY

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## **ACRONYMS**

DBdd	Day
FIS	
HAVENHCFAHRGhhHIPPS	Health Care Financing Administration Home Health Resource Group Hour
ID	
Kbps	Kilobits per second
LUPA	Low Utilization Payment Adjustment
MDCN	
OASISOBQIOSCAR	Outcome Based Quality ImprovementOutcome Based Quality Management
PCPEPPPS	Partial Episode Payment
RAMRAPRHIRUGs	Request for Anticipated PaymentRegional Home Health Intermediary
SCICss	
URL	Uniform Resource Locator
WWW	World Wide Web
yyyyYear	

## **GLOSSARY**

**Body record (Data record)** – the body or data record contains information on a single OASIS-B1 patient assessment.

<u>Consistency required</u> – information provided about logical relationships between the current field and other fields in the data record (e.g., skip patterns, checklist patterns, and data relationships).

<u>Data specifications (specs)</u> – specifications encoding of each data field, document descriptions, date consistency rules, submission timing rules, record sequencing rules and submission of corrections.

<u>Encryption</u> - system to translate plain text into scrambled code. Encryption offers a higher level of security when electronically transmitting data.

**End** – the ending position (byte) of the data item in the record layout.

<u>Fatal file error</u> – an error resulting in total rejection of the submitted file.

**Fatal record error** - an error resulting in rejection of a single record.

<u>File structure</u> – a valid submission file consists of fixed length ASCII records. Each submission file consists of a Header Record (as the 1<sup>st</sup> record), one or more Data Records, and a Trailer Record as the last record.

**Format info** – information provided on how data must be formatted (e.g., right justified, zero filled, etc.).

<u>Header record</u> – contains basic identifying information for the home health agency submitting OASIS-B1 data, as well as, contact persons and telephone numbers to be used in the event the file is in error.

**Item description** – a verbal description of the data field.

**Item identifier** - an unique name for each field in the record layout.

**<u>Len</u>** – is the length (number of characters or bytes) of the data item in the record layout.

<u>Lock date</u> – the date on which the assessment is locked (finalized) in the user's encoding software to prevent further editing.

<u>Masking</u> - concealing of specified data elements. The data elements (those which can identify a specific patient) are masked prior to transmission. However, the individual identifiers remain unchanged in the original records.

<u>Other Follow-up Assessments</u> – can occur anytime after the start of care or resumption of care and is conducted due to a significant change (a major decline or improvement) in a patient's condition at a time other than during the recertification assessment's five-day window.

<u>Recertification (follow-up) Assessments</u> – assessments that must be completed every two calendar months after the start of care while the patient is receiving care.

**Record sequencing** – the sequence which assessment(s) must follow for a given patient.

**Record timing** – the timing which assessment(s) must follow for a given patient.

<u>Resumption of care</u> – care resumed following an inpatient stay by a patient currently receiving services from a home health agency.

**Start** – the starting position (byte) of the data item in the record layout.

<u>Start of care</u> – the date on which the patient was admitted to the home health agency and the first reimbursable service is delivered.

<u>Trailer record</u> – indicates the end of the submission file. The trailer record includes a count of the total records in the file, including the header and trailer records.

<u>Warning error</u> – an error that will not result in rejection of a record and will be stored onto the state's system.